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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 28, 2017	2017_628680_0005	008599-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.2) LP
c/o Southbridge Care Homes 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

MAITLAND MANOR
290 SOUTH STREET GODERICH ON N7A 4G6

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

TRACY RICHARDSON (680), ALI NASSER (523)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 8, 9, 10, 11, 12, 2017.

The following intakes were inspected during the Resident Quality Inspection:
Log #000181-17, Critical Incident #0965-000016-16, related to falls
Log #032281-16, Critical Incident #0965-000014-16, related to falls
Log #031566-16, Critical Incident #0965-000013-16, related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Registered Dietician, the Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses, Registered Nurses, Personal Support Workers, pharmacist, family members, Resident Council Representative, Family Council Representative, and residents.

The inspector (s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector (s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long Term Care Information and inspection reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set for a specified resident was provided as specified in the plan.

A Critical Incident Report was submitted to the Ministry of Health and Long Term Care related to a fall for a specified resident.

Review of the care plan revision stated to ensure a safety device was attached to the resident at all times to alert staff. Further review showed registered staff had done a care plan review for the resident on a specific date. The care plan was subsequently updated to state that the staff were to ensure a safety device was attached at all times, to alert staff.

During interviews with the staff that had been working at the time of the fall, the registered staff member stated that the resident did not have the safety device in place because the resident was independent with their mobility. The registered staff member stated that the resident was supposed to have the safety device in place but could not remember if the resident did or not. A staff member stated that they could not remember if the resident had the safety device on but stated the resident was independent in that care area.

The Administrator stated that if a resident had a safety device, staff would document the monitoring of the safety device on the flow sheet. The Administrator acknowledged there was no record on the flow sheets of that occurring. The Administrator stated that the staff members were not checking for a safety device for the resident on the flow sheets, which would indicate that the resident did not have the safety device in place.

The licensee failed to ensure that the care set for a resident was provided as specified in the plan.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on September 23, 2014, August 24, 2015 and May 16, 2016. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10 s. s.114 (2) states that "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

The licensee policy titled Medication Room : stated to store all medication requiring refrigeration in a separate refrigerator upon receipt or store in a designated area of the refrigerator, the policy then stated:
1. Store all medication requiring refrigeration in a separate refrigerator upon receipt or store in a designated area of the refrigerator, separated from food and laboratory specimens.
2. The refrigerator must maintain a temperature suitable for storage of these medications (in most cases between 2 degrees C to 8 degrees C is optimal).

Observation on a specified date noted that specific medications were kept in a medication refrigerator in the medication room, there was no documentation of temperatures being taken for this medication refrigerator. A registered staff member stated they do not record temperatures of the medication refrigerator and did not know if the right temperature was maintained. The registered staff member stated that the vaccine fridge had temperatures taken twice per day and recorded on the documentation record for the vaccine refrigerator.

During an interview with the Director of Care they stated that there was no monitoring of the medication refrigerator as per policy and they had thought about getting a thermometer for it the other day.

The licensee has failed to ensure that drugs were stored in an area that complied with their policy regarding medication storage for those medications requiring refrigeration.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home. [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 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 (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

During an interview regarding skin and wound care a registered staff member stated that altered skin integrity assessments were completed by the registered nurses and then added to the Treatment Administration Record (TAR) for the registered staff to monitor. The registered staff member stated that the Registered Nurse sets up the altered skin integrity care in the TAR and then the registered practical nurse's monitor the altered skin integrity and observe for changes.

A registered staff member stated that they completed the altered skin integrity assessment on a specific date for the resident. The registered staff member stated that

this was the first assessment completed since the resident was admitted according to the documentation. During the interviews it was noted that on some shifts there were no registered nurses working.

Further review of the documentation showed that there was no charge registered nurse working days on the date of admission, and a registered practical nurse (RPN) had worked as a charge nurse on the specified date.

The Administrator reviewed with the inspector the rotation for registered staff, there were fourteen shifts that were not covered by an RN that was a regular member of the nursing staff of the home.

The Administrator stated that the RN’s are to do both the treatment and the assessments on altered skin integrity in the home, they can delegate a specific treatment to the RPN's if they do not have time, however the RN's are the leads on altered skin integrity. The Administrator stated that RPN’s, or an agency nurse would do the charge position when there was no RN coverage.

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 9, 2014, January 23, 2015 and September 24, 2015. [s. 8. (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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations and to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of the residents admission.

Record review showed that a specified resident was admitted to the home on an identified date. Further review showed the first Head to Toe Skin Assessment and the first Weekly Impaired Skin Integrity Assessment was completed greater than 24 hours after admission. On a specified date an Inter RAI assessment was completed with a specific score greater than one.

Review of the Policy Skin and Wound Program: Prevention of Skin Breakdown, stated on admission:
1. Assess the resident for risk of skin breakdown using the specified assessment

2. For those residents who score >one on the assessment, conduct a Head-to-Toe Assessment: within twenty four hours of admission.

Registered Nurse (RN) stated that the resident was admitted with altered skin integrity. The RN stated that they completed the altered skin assessment on a specific date. The RN stated that according to the documentation this was the first assessment completed since the resident was admitted.

Director of Care (DOC) stated that a Head to Toe Skin Assessment was to be completed within 24 hours of admission and that this had not been completed on the resident. The DOC stated that the first weekly wound assessment was completed at the same time and the expectation was that the resident should have had both completed within 24 hours of admission.

The licensee has failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within twenty four hours of admission. [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Record review for a specific resident showed that the resident was admitted to the home on an identified date. The Hospital Minimum Data Set Home Care (MDS-HC) from the Community Care Access Centre (CCAC), stated that the resident had altered skin integrity, and that the resident received certain medications prior to a specified treatment. Review of the Discharge Summary from the hospital, stated the resident had specific altered skin integrity and that the resident found the treatment uncomfortable.

Record review showed an assessment was completed on a specified date. The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) showed the first documented treatment was completed on a different date.

A registered staff member stated that the Registered Nurses (RN's) do the altered skin integrity treatment and that the registered staff members did not complete the altered skin integrity treatment on admission for the resident. A registered staff member stated that the resident had a specified treatment when they were admitted, and had been told

about the treatment at change of shift. The registered staff member stated that staff turned the resident and that the resident had a dressing over the altered skin integrity area but the registered staff member did not assess the altered skin integrity at that time. A Registered Practical Nurse (RPN) stated that the skin assessment had to be done within 24 hours of admission per policy. The RPN stated the resident was admitted on a specific shift, and they did not look at the altered skin integrity. The Registered Nurse stated that according to the documentation, they did not do the treatment or assess the altered skin integrity on that day. The registered staff member acknowledged that if the treatment was completed it would have been documented in the Treatment Assessment Record (TAR). The registered staff member shared that they do not remember doing the treatment for the specified resident during the admission period.

Director of Care stated the altered skin integrity should have had the treatment done routinely and that it was not completed according to documentation. The DOC stated that the altered skin integrity should have been looked at within the first 24 hours.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation issued in the home on August 24, 2015 in a Resident Quality Inspection. [s. 50. (2) (b) (ii)]

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, (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission, (ii) upon any return of the resident from hospital, and (iii) upon any return of the resident from an absence of greater than 24 hours. To ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who had a change in a specific area received an assessment that included identification of causal factors, patterns, and potential to restore function with specific interventions.

A clinical record review for a specific resident, the Minimum Data Set (MDS), showed that the resident's specific assessment score was zero.

A clinical record review for the MDS, showed that the resident's specified assessment score was one.

A clinical record review showed no assessment that included identification of causal factors, patterns, and potential to restore function with specific interventions was completed when this change in assessment occurred.

The registered staff member said in an interview that the resident had shown an occasional change in a specific area. The registered staff member said that the last specified assessment had been completed on an identified date, no other specific assessments were done after that date.

The Director of Care (DOC) acknowledged in an interview that the resident had a change in condition on a specified date, resident assessment score for the specified area went from score of zero to one, and expected that the resident would have a specific assessment completed.

DOC acknowledged that an assessment was not done for this change. DOC stated that the resident had a change in condition and said that it was their expectation that the assessment be completed for the resident.

The licensee has failed to ensure that the resident who had a change in a specific area received an assessment that included identification of causal factors, patterns, and potential to restore function with specific interventions.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation issued in the home on August 24, 2015 in a Resident Quality Inspection. [s. 51. (2) (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, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

Review of the Medication Incident reports during this inspection showed that a controlled medication patch was found to be missing from an identified resident. Progress note in Point Click Care stated that on the identified date the controlled medication patch was not found on the resident.

Review of the policy Narcotics and Controlled Drugs, stated that "narcotics or other controlled drugs are missing or have been tampered with, the Director of Care will notify: b. The Ministry of Health, c. the police as per jurisdictional requirements."

The Director of Care (DOC) stated that a critical incident report was not completed and was unsure if one was required. The DOC stated that the police were not notified of the missing controlled substance patch.

The Administrator stated that the expectation is for the policies to be followed and that a critical incident report should have been completed and submitted as required.

The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance. [s. 107. (3) 3.]

2. The licensee has failed to ensure that when the Director was informed of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident.

A review of a Critical Incident System (CIS) submitted to the Ministry of Health and Long Term Care (MOHLTC), showed that a specified resident had a fall and was transferred to hospital with a specific injury. The resident returned to the home on an identified date, after treatment for the specific injury. A review of the CIS showed no updates had been completed for the CIS after the initial submission.

A review of CIS completed on an identified date, showed that the resident had a fall on a specific date, transferred to hospital, for assessment of a possible injury. The resident returned to the home, after treatment for the specific injury. A review of the CIS, showed no updates had been completed for the CIS after the initial submission.

The Administrator said that the expectation was for the Critical Incidents to be updated with the information needed. The Administrator said that the DOC along with themselves receive the request for updates. The Administrator then would confirm that the DOC had completed the updates.

Administrator reviewed the Critical Incidents, and acknowledged they were not updated within 10 days, the Administrator stated that their expectation was for the CIS to be completed and updated.

The licensee has failed to ensure that when the Director was informed of an incident within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection. There was a compliance history of this legislation issued in the home on July 20, 2016. [s. 107. (4) 4.]

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 Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance,
and to to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

WN #7: 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).

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 has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, or the resident's substitute decision maker (SDM) if any, the pharmacy, and the Medical Director.

Review of the Medication Incident reports for a specific time frame, showed that there were thirty five medication incidents reported. Thirty one of the incident reports showed no documentation that pharmacy had been notified. Twenty three reports showed no documentation that the doctor had been notified ,and eight medication incident reports showed no documentation that the family had been notified.

Review of the Medication Incident Summary from Advantage Care Pharmacy Services showed:
-On a specified date, one incident report was reviewed by pharmacy.

-In an identified month, showed that there were two incidents reviewed by pharmacy.

Director of Care (DOC) stated that the DOC would mark on the form when notification was completed. DOC further acknowledged that there were many incidents that were missing notifications, and if the notifications had occurred it was normally written on the form.

The Pharmacist stated that the nurses had not been faxing all the incidents to pharmacy, and that the pharmacy was unaware of the amount of incident reports in the home until a specified date. On that date the Director of Care asked the Pharmacist to review all the reports. The Pharmacist stated that this was the first time the issues were brought to their attention. The Pharmacist stated that pharmacy had received medication incident reports that were concerning pharmacy errors, and that they have received approximately two or three of those a month. The Pharmacist was not aware of the other incident reports recorded until a specified date.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, or the resident's substitute decision maker (SDM) if any, the pharmacy, and the Medical Director. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents were reviewed and analyzed, and a written record was kept of everything required under the clause (a) and (b).

Review of the policy titled Medication Incidents and Error Reporting stated "The pharmacy will review all medication errors, including medication incidents and near misses made on a monthly basis and perform a medication incident analysis, to determine root cause of errors, contributing factors, and develop strategies to reduce the risk of similar incidents."

An email with an identified date, from the Pharmacist to the Director of Care (DOC) after the inspector had asked for an analysis. The Pharmacist completed an incident report analysis for those specified dates. This analysis showed 18 medication incidents in an identified month, seventeen medication incidents in another month, and twelve medication incidents in another identified month.

During an interview, the Pharmacist shared that the analysis of medication incidents was not normally completed by the pharmacist, but that the pharmacy had a department who

did the analysis for the home. The Pharmacist stated that to be clear they were not aware of all incidents until the identified date, when the DOC brought it to their attention, at which time an analysis of all the medication incidents occurred.

DOC stated the quarterly analysis was not done that quarter at the Professional Advisory Committee meeting (PAC) due to the fact that the pharmacist and the doctor were not present. DOC stated they had asked pharmacy to review the incidents on a specific date, and that previous to this time, not all medication incidents were sent to pharmacy to review. DOC stated that the issue regarding medication incidents not being sent to pharmacy was discovered at a quality meeting approximately a month ago and that a plan was developed to correct this situation.

Record review of the minutes from the Quality Improvement Committee for a specific date, showed that for the an identified month, four medication incidents were reported, for the following month nine medication incidents had been reported and for the next month nine medication incidents and two pharmacy errors had occurred.

The Administrator acknowledged that not all the medication errors had been discussed at the Quality Improvement Committee meeting in a specified month.

The licensee has failed to ensure that all medication incidents were reviewed and analyzed, and a written record was kept of everything required under the clause (a) and (b).

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of the inspection. There was a no history of non-compliance of this legislation. [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 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 (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
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; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b)
and to 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; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

Issued on this 13th day of September, 2017

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

Original report signed by the inspector.