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

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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
Nov 29, 2016	2016_248214_0023	030216-16	Resident Quality Inspection

Licensee/Titulaire de permis

CANADIAN REFORMED SOCIETY FOR A HOME FOR THE AGED INC.
337 STONE CHURCH ROAD EAST HAMILTON ON L9B 1B1

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

MOUNT NEMO CHRISTIAN NURSING HOME
4486 Guelph Line BURLINGTON ON L9T 2X6

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

CATHY FEDIASH (214), GILLIAN TRACEY (130)

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): October 21, 24, 25, and 27, 2016.

Please note: The following inspections were conducted simultaneously with this RQI:
-Critical Incident System Inspection 011478-16 related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; Food Service Supervisor (FSS); Life Enrichment Coordinator; registered staff; Personal Support Workers (PSW); President of Residents' Council; residents and families. During the course of this inspection, the Inspector's toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; reviewed a Critical Incident System (CIS) submission; reviewed relevant investigative notes and medication incident reports and observed the administration of medications.

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

During the course of this inspection, Non-Compliances were issued.
- **6 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	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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The Home's Wound and Skin Care Program , page 2, directed registered nursing staff to make referrals to the interdisciplinary team members.

A) Resident #105 sustained skin tears on three identified dates in 2016. The Food Service Supervisor (FSS) confirmed in an interview on an identified in 2016, that referrals were not made for the Registered Dietitian (RD), as per the home's policy.

B) According to the clinical record, resident #103 sustained a skin tear on an identified date in 2016. The FSS confirmed the RD did not receive a referral as per the home's policy.

2. A review of the following home and the home's pharmacy policies stated the following:

A) The home's pharmacy policy titled, "Medication Reconciliation (New Admissions and Re-Admissions" (4-3 with an updated date of March 2016) stated the following:

i) The Medication Reconciliation form is to be filled out completely for all new admissions and readmissions.

ii) Nurses are to ensure all areas are correctly and completely filled out which includes the facility name, unit name, date, new or re-admission, physician's name, room number and bed, resident's date of birth, sex, health care number, diet and all medical conditions.

iii) Along with the medication name, the strength, quantity, frequency, route, info source (using legend at bottom of page identify the source of information, e.g. daughter, son, family friend, etc.) and the date the last dose was given.

B) The home's policy titled, "Medication Reconciliation" (Manual: Nursing-Affiliated Services. Section: Pharmacy and dated November 2014). A review of this policy stated the following:

i) For New Admissions: Registered staff to make a list of medications documented in the CCAC referral-the list can be a photocopy of the list from the referral or the list can be written out. Do not use this list without checking it thoroughly as it is often outdated. It does however provide valuable historical data.

ii) The nurse will cross reference the CCAC list of medications against the medications brought from the home or the transfer sheet. Make note of any discrepancies or changes in medications.

C) A review of the home's pharmacy policy titled, "MAR/TAR Documentation" (8-1 with a review date of August 2013) stated the following:

i) When the MAR/TAR sheets arrive at the home, the nurse cross checks with any new physician's orders and current MAR sheets for accuracy of the following:
a. Name of the resident
b. Name of the medication
c. Strength of the medication
d. Dosage form
e. Route of administration
f. Frequency of administration
g. Duration of therapy if specified
h. Other information such as medical conditions, allergies, advanced directives, restraints, alcohol intake, dialysis, diet supplements, modifications and restrictions, IV medications, oxygen, vitals, weight, PASD, BP, catheter/irrigation, compression stockings, etc.

ii) The registered staff signs the MAR/TAR sheets with their designation (e.g. RN or RPN) and records the time and date, indicating the cross check is completed.

iii) A second registered staff must also check the new MAR/TAR against the current MAR/TAR, and verify against the physician's orders. The same cross checking process described above is performed as an independent double check. The second staff also signs with date, time and designation.

iv) After a medication is administered the nurse must initial the appropriate time and date box across from the medication. If a medication is not given, the reason must be entered using the appropriate code (codes may be facility/corporate specific):

Codes:
1- Leave of Absence (LOA) WITH MEDS
2-DRUG REFUSED
3-ABSENT FROM HOME
4-NOT APPLICABLE (N/A)
5- HOLD SEE NURSE
6- HOSPITALIZED
7- SLEEPING
8- NAUSEATED/VOMITING
9- DRUG HOLIDAY
10- SELF MEDICATING

A review of a CIS that was submitted by the home on an identified date in 2016, indicated that resident #110 had been prescribed 50 mg of an identified medication, one tablet to be taken daily at a prescribed time and 100 mg of the same identified medication, one capsule to be taken three times daily at specified time periods. The CIS indicated that the resident had received the wrong dose of the identified medication prescribed at 100 mg, and as a result, was transferred to hospital.

A review of resident #110's clinical record indicated that the resident was admitted to the home on an identified date in 2016. An interview with registered staff #043 confirmed that they had completed the resident's admission medication reconciliation on the date of the resident's admission. Registered staff #043 stated that the resident's family had brought in the resident's dosette package of medications from home. The staff member stated that the back of the dosette pack was photocopied and used for the purpose of medication reconciliation. A review of the photocopied documented that was taken from the back of the dosette pack indicated that the back of the dosette package contained the name of the pharmacy that the medications were dispensed from along with a listing of each medication name, the quantity of each medication and prescription number, the

dose for each medication, directions for the administration of each medication, the name of the prescriber, a description of each medication and a table that identified how many of each medication were to be given at breakfast, noon, supper or bed time.

Registered staff #043 stated that the resident's medications brought from home had been the only source used to complete the admission medication reconciliation and that they had not used the medications listed on the Community Care Access Centre (CCAC) application as this information is usually old and outdated. An interview with the DOC confirmed that the home had not used the medication list from CCAC and that the home had not complied with their policy.

A review of the admission medication reconciliation and physician order form identified that three pages in total were used to complete the medication reconciliation. On page one of the forms the "info source" had not been completed for all identified medications listed and the "date the last dose given" had not been completed on page two of the form for two medications listed.

A review of the admission medication reconciliation and physician order form identified that the form contained an area for "Nurse 1 Signature" and "Nurse 2 Signature". A review of resident #110's admission medication reconciliation form identified that only "Nurse 1 Signature" had been completed by registered staff #043 and the area for "Nurse 2 Signature" was blank. An interview with registered staff #043 and #040 confirmed that they had reviewed the resident's admission medication reconciliation form together. Registered staff #040 confirmed that they had not signed the form as registered staff #043 stated they would have the oncoming evening registered staff sign the medication reconciliation form. An interview with the DOC confirmed that the home had not completed the admission medication reconciliation and physician order form completely with recording the info source and the date the last dose of medication had been given, for each medication listed. The DOC and the pharmacy consultant confirmed that two registered staff signatures were to be completed on the medication reconciliation forms and had not been. The DOC confirmed that the home had not complied with their pharmacy "Medication Reconciliation" policy.

During an interview with registered staff #043 and the pharmacy consultant, it was shared that when the medication reconciliation form is completed, a handwritten paper Medication Administration Record (MAR) is created through a carbon copy. A review of the handwritten paper MAR that was generated from the medication reconciliation identified that there was an area titled, "Checked By". No registered staff signatures,

designation or dates were on the handwritten paper MAR that was generated from the medication reconciliation. The pharmacy consultant and the DOC confirmed that the handwritten paper MAR was to be signed by two registered nursing staff identifying that the MAR had been checked for accuracy.

An interview with the pharmacy consultant identified that the pharmacy will send an electronic paper MAR the same day with the medication delivery. This electronic paper MAR then replaces the handwritten paper MAR that was generated by the medication reconciliation form. A review of the electronic paper MAR that was sent by the pharmacy on the date the resident was admitted, identified that there were two areas on the bottom of this MAR that stated, "Checked By" and "Staff Signature". A review of the electronic paper MAR showed that only one registered staff had signed their name and designation and dated this MAR; however, no time was included. An interview with the DOC and the pharmacy consultant confirmed that the electronic paper MAR was to be checked and signed by two registered staff, prior to being implemented.

A review of the handwritten paper MAR that was generated from the completion of resident #110's admission medication reconciliation as well as the electronic paper MAR that was sent from the pharmacy on the date the resident was admitted, had shown that the identified medication prescribed at 100 mg that was scheduled to be administered at two identified times on a specified date, had not contained any documentation to identify if the medication was administered or not administered and was blank.

An interview with registered staff #043 stated that registered staff will administer the medications prescribed to the new resident but will wait to sign on the electronic MAR that comes from the pharmacy the same day along with the medication delivery.

An interview with registered staff #021 who worked on a specified shift on the date the resident was admitted, was conducted. The registered staff member stated that they could not recall if they had administered the resident's identified medication that was prescribed at 100 milligrams for the two identified scheduled time's of administration on the day the resident was admitted. The DOC confirmed that both the handwritten paper MAR and the electronic paper MAR had not been completed with two registered staff signatures, designations, date and time. The DOC also confirmed that the resident's identified medication prescribed at 100 mg that was scheduled to be administered at identified times on the date of the resident's admission, had not contained any documentation to identify if the medication was administered or not administered and was blank. The DOC confirmed that the home had not complied with their pharmacy

"MAR/TAR Documentation" policy.

This non-compliance was issued as a result of the following CIS inspection #011478-16. (Inspector #214) [s. 8. (1) (a),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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of a CIS that was submitted by the home on an identified date in 2016, indicated that resident #110 had been prescribed 50 mg of an identified medication, one tablet to be taken daily at a prescribed time and100 mg of the same identified medication, one capsule to be taken three times daily at specified time periods. The CIS indicated that the resident had received the wrong dose of the identified medication prescribed at 100 mg, and as a result, was transferred to hospital.

A review of resident #110's clinical record indicated that the resident was admitted to the home on an identified date in 2016.

An interview with registered staff #043 who completed the resident's admission medication reconciliation as well as a review of a progress note dated on the resident's date of admission, confirmed that they had faxed the completed medication reconciliation to the home's pharmacy and had spoken over the telephone with the home's pharmacist and reviewed the resident's medications.

A review of the resident's progress notes on a specified date and time, indicated that the resident seemed very confused; opened their eyes when called and would fall asleep the next second; unable to follow verbal direction; staff unable to feed the resident as they were falling asleep. Progress notes dated later the same day indicated that the resident was restless at times and refused meals at supper. Progress notes the following morning indicated that the resident's oxygen saturation at room air was measured at an identified rate and that the resident was awake but confused. Progress notes dated later the same day indicated that the physician had documented that the resident's oxygen saturation had decreased to an identified rate and the resident was transferred to hospital this same day. A progress note on the date the resident was transferred to hospital indicated that the resident's medications for the same day and the following day, accompanied the resident to hospital as requested by ambulance staff.

A review of the CIS submitted by the home indicated that a family member of the resident had discovered the medication error while at the hospital with the resident, when they checked the resident's medication packages that had accompanied the resident to the hospital. It had been identified that instead of one capsule of the 100mg of identified prescribed medications in each pouch, there had been three capsules in each pouch. The CIS indicated that the resident had received a total daily amount of 950 mg of the identified prescribed medication instead of the prescribed total daily amount of 350 mg. The CIS indicated that the resident returned back to the home four days later and that their health status had returned to normal.

An interview with the pharmacy consultant as well as a review of the pharmacy's written response to this medication incident indicated that when the resident's admission orders were received at the pharmacy, the resident's identified medication prescription of 100mg capsule, three times daily was inputted incorrectly into the pharmacy computer system. The identified prescription was entered instead as 100mg, three capsules, three times daily and sent to the pharmacy's Pacmed machine that packages the medications. The error was caught by the pharmacist and corrected. The pharmacy's written response to the error stated that the correction to the order was done at an identified time on the date the resident was admitted and a partial filling of medication pouches with the correct

dose of the identified prescribed medication for an identified period of three days following the resident's admission to the home, had been produced. The pharmacy's written response to the medication error as well as an interview with the pharmacy consultant indicated that when the first inputter had sent the prescription to the pharmacy's Pacmed machine, they had not completed the first check with the pharmacist that was to be completed prior to sending the prescription to the Pacmed machine and as a result, the wrong prescription remained in the pharmacy's system and it was this prescription that filled the full weekly medication pouches for the week following the resident's admission to the home. The pharmacy's written response to the medication incident stated that the full weekly strip production was started in the afternoon of the date the resident was admitted to the home, prior to the error being corrected.

An interview with the DOC and a review of the home's investigation notes indicated that registered staff #018, #021 and #045 had administered the wrong dose of the identified medication prescribed at 100mg capsules on four identified day's as well as at an identified time of administration on the fifth day in 2016. The DOC confirmed that the identified staff had not checked the medication pouches accurately with the MAR prior to administration of the identified prescribed medication doses. The DOC confirmed that resident #110's prescribed medication had not been administered in accordance with the directions for use specified by the prescriber.

This non-compliance was issued as a result of the following CIS inspection #011478-16. (Inspector #214) [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

During a tour of the home on an identified date in 2016, a container of Neutral Disinfectant Cleaner was observed in an unlocked cupboard in the secured area kitchen and the "Supply" room located next to the secured area was unlocked and contained four litres of disinfectant. The DOC confirmed the disinfectant should have been inaccessible to residents and the supply room door locked at all times. [s. 5.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 61. Family Council assistant

Specifically failed to comply with the following:

s. 61. (1) If the Family Council so requests, the licensee shall appoint a Family Council assistant who is acceptable to that Council to assist the Family Council. 2007, c. 8, s. 61. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at the request of the Family Council, the licensee appointed an assistant to the Family Council to assist the Council who was acceptable to the Council.

It was confirmed in an interview with the Family Council President and the Life Enrichment Coordinator that an assistant had been requested by the Family Council, but the home had not appointed the assistant to assist the Council. [s. 61. (1)]

WN #5: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results.

The Family Council President completed the Family Council President or Delegate Questionnaire and indicated that the Council had asked to be included in the rewriting of a survey and were told they would be; however, another survey was sent out and they were not consulted. The Family Council President confirmed in the questionnaire that there were changes that they would like to see on the survey. The Administrator confirmed in an interview that the home had sent out a survey since meeting with the Council and that the survey had not been revised. [s. 85. (3)]

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):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was 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): 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

A review of a CIS that was submitted by the home on an identified date in 2016, indicated that resident #110 had been prescribed 50 mg of an identified medication, one tablet to be taken daily at a prescribed time and 100 mg of the same identified medication, one capsule to be taken three times daily at specified time periods. The CIS indicated that the resident had received the wrong dose of the identified medication prescribed at 100 mg, and as a result, was transferred to hospital.

A review of the submitted CIS and an interview with the DOC confirmed that the home became aware of the medication incident two business days prior to informing the Director. The DOC confirmed that the home had not informed the Director of this medication incident within one business day of becoming aware of the medication incident.

This non-compliance was issued as a result of the following CIS inspection #011478-16. [s. 107. (3) 5.]

Issued on this 16th day of December, 2016

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

Original report signed by the inspector.