Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2019	2019_543561_0019	012077-19	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Anson Place Care Centre
85 Main Street North Hagersville ON N0A 1H0

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

DARIA TRZOS (561)

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): August 8, 2019.

A Critical Incident System 2786-000007-19, log #012077-19 was conducted during this inspection related to an incident causing a change in resident's condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

During the course of the inspection, the inspector: observed medication administration, reviewed investigation notes, clinical records, education material, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

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 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.

In accordance with O. Reg 79/10 s. 114(2), the licensee was required to have written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and drug destruction of all drugs used in the home; and in reference to O. Reg 79/10 s. 131(2), the licensee was required to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home's policy titled "Medication Administration, Independent Double Medication Check for High Alert Medications", Index I.D: F-05-05, dated September 18, 2018, stated that high alert medications were to be administered by the nurse after she/he completed independent double check. The checks were to be performed by two nurses. If there was no second nurse on duty in the building the nurse was to perform the first check, then was to start working on a different task, then was to complete the second check independently, starting the process from the beginning.

A Critical Incident System (CIS) was submitted to Ministry of Long Term Care (MOLTC) on an identified date in 2019, indicating that there was a medication incident which caused a change in the resident's health status.

Resident's clinical records indicated that resident #001 received the wrong type of an identified medication in 2019. Resident #001 was sent out to the hospital and received further treatment. The resident returned to the home the next day and was monitored further.

RPN #103 was interviewed and stated that prior to administering the medication to the resident they did not show the medication to another RPN as indicated in the home's policy. RPN #102 was interviewed and stated that they did not check the medication prior to RPN #103 administering it to resident #001.

The DOC was interviewed and stated that it was the home's policy that registered staff do the double check when there was more than one registered staff on the unit. The DOC stated that RPN #103 should have shown the medication to RPN #102 and RPN #102 should have checked the medication prior to it being administered.

The licensee failed to ensure that the home's "Independent Double Medication Check for High Alert Medications" policy was complied with. [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 Critical Incident System (CIS) was submitted to Ministry of Long Term Care (MOLTC) on an identified date in 2019, indicating that a medication incident caused a change in the resident's health status.

The CIS indicated that RPN #103, administered an identified medication to resident #001 which was not the one prescribed by the physician. The error was caught immediately by RPN # 102, and the resident was sent out to the hospital where they had received treatment.

Investigation notes including resident's clinical records indicated that resident #001 received the wrong type of medication on an identified date in 2019. The physician order was reviewed and showed that the wrong type of medication was administered to resident #001. Resident #001 was sent out to the hospital for further treatment. The resident returned to the home the next day and was monitored further .

RPN #103 was interviewed and stated that they administered the wrong medication to resident #001 on an identified date in 2019. They stated that they checked the medication prior to administering; however, took the wrong one from the medication cart. As soon as they administered it to the resident they became aware that it was the wrong medication. They immediately reported it to the RN on the unit.

RPN #102, was interviewed and stated that they observed RPN #102 check the medication and administering it to the resident. When they returned to the medication cart, they noticed that the medication was wrong. The RPN immediately notified the RN on the unit. Resident was sent out to the hospital for further assessment and treatment.

The DOC was interviewed and confirmed that the wrong medication was administered to resident #001 by RPN #103.

The licensee failed to ensure that the medication was administered to resident #001 as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 9th day of September, 2019

[redacted]

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

Original report signed by the inspector.