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

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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 5, 2013	2013_210169_0029	H-00064-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

NORTHRIDGE
496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2

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

YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 24, 25, 28, 29, 30, 2013

This inspection refers to Logs # H-000064-13, H-000605-13 and H-000645-13

During the course of the inspection, the inspector(s) spoke with nursing and housekeeping staff, Director of Care, Pharmacist and Administrator and residents.

During the course of the inspection, the inspector(s) reviewed clinical records, drug record books, the homes policy and procedures, critical incident system records, reviewed minutes of meetings and observed all care areas.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Medication

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 did not ensure that Resident #3 received the care set out in their plan of care. The plan of care for Resident #3 identified that if Resident #3 refuses care, to stop and return in a few minutes and try a different approach. The plan also stated that Resident #3 needs to be checked frequently throughout the day. The personal support worker, did not provide this care after entering Resident #3 room. When the personal support worker entered Resident #3 room and asked the resident if they required any assistance, the resident stated they did not require assistance. The personal support worker left the resident's room and did not check on the resident frequently as per the plan of care . When the resident was checked later that morning, they were found in a condition not desired by the resident. The resident did not receive care as per their plan of care. [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 that ensures all residents receive care as per their plan of care, 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 did not ensure that the plan, policy, protocol, procecdure, strategy or system instituted or otherwise put in place was complied with. The policy named Medication Administration Index #LTC-F-20 states the medications will be administered following the 'rights' of medication administration. Resident #1 received a double dosage of medication for four days. The nursing staff did not follow the home's policy and check the medication in the pouches were the correct dose resulting in the resident receiving two tablets instead of one tablet.
Also, the policy from Classic Care pharmacy named "Ordering and Receiving Medication" Policy number 2.5 was not complied with. The nursing staff did not verify the strength of the medication or sign their name on the detailed "automed Report" when the drug came into the home. The pouches contained two tablets instead of the prescribed one tablet. The nursing staff also did not verify the pouch of medication being administered contained the correct dosage of medication, resulting in the resident receiving a double dosage for 3.5 days.

The medication administration records confirm the resident received the dosage in error. The nursing staff, pharmacist and Director of Care confirmed the error occurred. [s. 8. (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 that ensures all plans, policies, protocols, procedures, strategy or systems instituted or otherwise put in place are complied with, to be implemented voluntarily.

WN #3: 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):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was notified no later than one business day after a medication incident occurred resulting with the resident being transferred to the hospital. Resident #1 received a double dose of medication for 3.5 days and was sent to the hospital on the direction of the Director of Care for monitoring. The critical incident was submitted to the Ministry of Health eight days after the resident was sent to the hospital. This was confirmed by the critical incident documentation. It was also confirmed by the Director of Care and Administrator. [s. 107. (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 that ensures the Director is notified no later than one business day after a medication incident occurs resulting with the resident being transferred to the hospital, to be implemented voluntarily.

WN #4: 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 did not ensure that a drug, was administered in accordance with the directions for use as specified by the prescriber. The doctor changed the dosage to one tablet twice per day. Resident #1 received two tablets twice per day for 3.5 days, a double dosage. The resident did not receive the correct dosage according to the doctors directions. The resident went to the hospital, however it was for a different health concern. [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 that ensures that all drugs administered are in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

Issued on this 5th day of November, 2013

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