Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 30, 2020	2020_796754_0021	010685-20, 011043-20	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Pinecrest Manor
399 Bob Street P.O. BOX 220 LUCKNOW ON N0G 2H0

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

TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 27-29, 2020.

The following intakes were completed during this Complaint inspection:
Log #011043-20, a complaint related to a resident not receiving medication as prescribed and concerns with the home's nutrition/hydration program,
Log #010685-20, related to a medication incident.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care (DOC) the Associate Director of Care (ADOC), Registered Nurse (RN), and Registered Practical Nurse (RPN).

The inspector made observations of the home, dining service, and resident/staff interactions. A record review of the plan of care for the identified residents was completed. The home's relevant documentation were also reviewed.

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)**
- **1 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. 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 resident #001, #002,

and #003 in accordance with the directions for use specified by the prescriber.

The Ministry of Long Term Care received a complaint that resident #001 did not receive their medication as ordered.

A) Resident #001's physician's orders included that they were to receive a prescribed amount of a medication two times per day. The May 2020, electronic medication administration record directed that medication was to be given twice per day.

A medication Incident report in May 2020, documented that registered practical nurse #107 gave resident #001 a partial dose of their prescribed medication. The electronic medication administration record documented that a partial dose of medication was given to resident #001 in May 2020, during evening rounds.

RPN #104 and Registered Nurse (RN) #103 said resident #001 received a partial dose of their evening medication and that it was not given as directed by the physician.

DOC #101 said RPN #107 should have called the emergency after hours pharmacy number to receive more medication instead of giving the partial dose of medication to resident #001 in May 2020.

B) Resident #002's physician orders included that they were to receive a prescribed medication taken three times per day. The March 2020 electronic medication administration record directed that medication was to be given at three different time periods throughout a 24 hour period.

A medication Incident report in March 2020, documented that agency RPN #108 administered resident #001's medications during one time period throughout the 24 hour period to resident #002. RPN #108 immediately realized this medication error and reported it to RN #103. Agency RPN #108 did not check resident #002's identification before medication administration.

The home's policy titled Long Term Care Medication Administration, with an effective date of August 31, 2016, directed staff to use two resident identifiers before administering medications. The home's policy provided examples of resident identifiers which included a digital photo identifier as the first identifier used.

DOC #101 said that agency RPN #108 gave the wrong medication to resident #002 and

they did not receive their medications as prescribed. They said that RPN #108 did not follow the home's policy of using two resident identifiers to ensure the correct resident was given their prescribed medications and resident #002 did not receive their medication as prescribed as a result.

C) Resident #003's physician orders included that they were to receive a prescribed medication one time a day three times per week.

A medication incident report in February 2020, documented that RPN #107 did not administer resident #003's prescribed medication once in February 2020. The medication incident report indicated this was an omission error.

DOC #101 said the precribed medication for resident #003 was documented as given on the electronic medication record in February 2020, but was not actually given. The medication was found later in a separate pack and staff then realized it had not been given.

The licensee failed to ensure that drugs were administered to resident #001, #002, and #003 in accordance with the directions for use 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.

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 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 any policy in place, the policy was complied with.

In accordance with LTCH, s. 12, and in reference to O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that the medication management program included policies to ensure accurate administration of all drugs used in the home.

Specifically staff did not comply with the licensee's policy titled Emergency After Hours Service, with an effective date of April 2017. This policy directed staff to call the emergency after hours pharmacy service for any medications or orders needed before the next business day. The policy included two emergency after hours pharmacy phone numbers that were specific to Pinecrest Manor.

The Ministry of Long Term Care received a complaint that resident #001 did not receive their medication as ordered.

Resident #001's physician's orders included that they were to receive a prescribed medication by mouth two times per day. The May 2020, electronic medication administration record directed that medication was to be given twice per day.

A medication incident report in May 2020, documented that registered practical nurse #107 gave resident #001 a partial dose of their prescribed medication. The electronic medication administration record documented that a partial dose was given to resident #001 in May 2020.

RPN #104 and Registered Nurse (RN) #103 said that RPN #107 should have called the emergency after hours pharmacy number when they did not have enough medication to give resident #001 so they could provide them with their full dose in May 2020.

DOC #101 said RPN #107 should have called the emergency after hours pharmacy number and that the home's policy titled Emergency After Hours Service was not followed when a partial dose of prescribed medication was given to resident #001 in May 2020.

The licensee 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 any policy in place, the policy was complied with when the home's policy Emergency After Hours Service was not followed when RPN #107 did not call the emergency pharmacy number to ensure resident #001 received their full dose of prescribed medication in May 2020. [s. 8. (1) (b)]

Issued on this 4th day of August, 2020

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

Original report signed by the inspector.