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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2017	2017_566669_0031	023550-17	Resident Quality Inspection

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

REGENCY PARK LONG TERM CARE HOME
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

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

ANDREA DIMENNA (669), ALICIA MARLATT (590)

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): November 6 to 10, and 14, 2017.

The following Complaint was completed with this inspection:

IL-49173-LO/Log #002713-17, related to falls.

During the course of the inspection, the inspector(s) spoke with residents, a representative of Residents' Council, the Administrator, the Director of Resident Care (DRC), the Resident Assessment Instrument Coordinator, a Registered Dietitian, two Registered Nurses, two Registered Practical Nurses (RPNs), three Health Care Aides, and six Personal Support Workers.

During the course of the inspection, the Inspectors 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. Inspectors observed medication administration and drug storage areas, staff-to-resident interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

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

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	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. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

During an interview with a Registered Practical Nurse (RPN) about the disposal of medication wrappers containing personal health information, they shared that the wrappers went into a bin in the medication room at the end of the shift and that the Maintenance Supervisor disposed of them. On further questioning, the RPN shared that the Maintenance Supervisor had keys to the medication room and disposed of the medication wrappers and sharps containers.

The home's policy, Medication Keys (No.3.5), last revised on March 1, 2016, stated: "The registered staff on duty is responsible for the security of medications and for the security of the keys for the medication cart and medication storage area. Medication storage areas must be kept secure at all times and the keys must be kept on the responsible registered staff at all times. Access to medication storage areas are restricted to persons who may prescribe, dispense, or administer medications and the Administrator."

The home's policy, Medication Room (No. 3.4), last revised on March 1, 2016, stated:

"The medication room is securely locked at all times. Access to the medication room is restricted to the personnel directly involved in the medication management process (i.e. persons who may dispense, prescribe, or administer medication), the Director of Care and the Administrator at the Home."

In an interview with the Director of Resident Care (DRC), they shared that the Maintenance Supervisor had keys to all of the medication rooms to take care of the sharps containers, spill kits and medication wrappers. The DRC acknowledged that the Maintenance Supervisor was not a person who could dispense, prescribe or administer medications and therefore should not have had access to the medication rooms unless supervised by the responsible registered staff member while performing their duties.

The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The severity of this issue was determined to be a level one as there was minimum risk, and the scope was widespread during the course of this inspection. The home had no history of non-compliance with this section of the legislation. [s. 130. 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 all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #2: 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).

s. 135. (3) Every licensee shall 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; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(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.

During the Resident Quality Inspection, medication incidents were reviewed from a specified date range.

The home's policy, Medication Incidents (No. 4.15), last revised on March 1, 2016, stated:
Procedure section:
"3. Initiate a Remedy'sRx Medication Incident/Near Miss Report documenting: resident name, date and time of incident, indicate type of incident and circle specific example, description of incident, medication involved, effect on resident, follow-up actions taken, attach a copy of MAR/eMAR report and any other supporting documentation, attach a copy of Medication pouch/copy of Medication Label if applicable.
4. Notify the Prescriber, if appropriate, of the incident.
5. Notify the Resident or POA (family representative) for any incidents reaching the resident and any follow-up actions taken.
6. Fax the incident report to the Pharmacy; forward to Director of Care for investigation."

A Medication Incident/Near Incident Report, from a specified date, described an incident where the administration of a medication to a resident was delayed as a result of a pharmacy error. The report showed that the only person who was aware of the medication incident was the Pharmacist, and the Pharmacist was the only person who signed the Medication Incident/Near Incident Report. There was no documentation on the report to support that the resident, the prescriber and the Director of Care were notified of the delay in therapy.

Another Medication Incident/Near Incident Report, from a specified date, described an incident where specific physician directions were not observed, and resulted in a resident receiving a medication when they should not have received the medication. The report documented the incident as an adverse event that reached the resident as the staff was required to monitor the resident as a result of the error. The report had no documentation to support that the resident or their Power of Attorney (POA) was notified of the incident.

In interviews with two RPNs, they shared that when a medication incident reached the resident, they were responsible for notifying the resident or their POA, the Physician, the pharmacy and the Director of Care as soon as possible.

In an interview with the DRC, they shared that all medication incidents that reached the resident should be reported to the resident or their POA. The DRC further shared that the prescriber, the Pharmacist and the Medical Director should be notified of all medication incidents. DRC #101 was unable to acknowledge whether or not the identified residents had been notified of these incidents as the DRC was not working in the home at the time of these incidents. The DRC stated the home's expectation was that the Medication Incident Reports were filled out as directed by the home's policy.

The licensee has failed to ensure that medication incidents involving two identified residents were reported to the resident, the resident's substitute decision-maker, if any, the prescriber and the Director of Care. [s. 135. (1)]

2. The licensee has failed to ensure that:
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed
(b) corrective action was taken as necessary, and
(c) a written record was kept of everything required under clauses (a) and (b).

The home's policy, Medication Incidents (No. 4.15), last revised on March 1, 2016, stated:
Policy section:
"A medication incident program is in place in the Home to ensure there is a consistent method for identification, reporting, reviewing and analyzing of all medication incidents. Registered staff must report medication incidents using the procedures below. All medication incidents are reviewed and analyzed quarterly by the Professional Advisory Committee (PAC) and recommendations for system improvements developed. The purpose of the medication incident program is to identify opportunities for improving the medication management system in the Home and to prevent future incidents from occurring rather than targeting individual practices."
Procedure section:
"3. Initiate a Remedy'sRx Medication Incident/Near Miss Report documenting: resident name, date and time of incident, indicate type of incident and circle specific example, description of incident, medication involved, effect on resident, follow-up actions taken, attach a copy of MAR/eMAR report and any other supporting documentation, attach a copy of Medication pouch/copy of Medication Label if applicable.
6. Fax the incident report to the Pharmacy; forward to Director of Care for investigation.
7. The Director of Care or Pharmacy Manager, as appropriate, investigates the medication incident, identifying factors contributing to the incident and documents

findings on the Medication Incident/Near Miss Report form.
8. The Director of Care or Pharmacy Manager, as appropriate, determines corrective actions to be taken to reduce the risk of similar incident occurring in the future."

A Medication Incident/Near Incident Report, on a specified date, showed that the areas to document the root cause analysis to identify contributing factors to the incident and to document the corrective action to prevent similar occurrences in the future were not completed.

In an interview with the DRC, they shared that they expected the staff to document on all sections of the Medication Incident/Near Incident Report as outlined by the home's policy and agreed that the form was incomplete. The DRC was unable to explain why the documentation on the Medication Incident/Near Incident Report was not completed as they were not working at the home at the time of the incident.

The licensee has failed to ensure that the medication incident involving an identified resident included a written record of corrective action that was taken. [s. 135. (2)]

3. The licensee has failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that 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 were implemented, and
(c) a written record was kept of everything provided for in clause (a) and (b).

The home's policy, Professional Advisory Committee (PAC) (No.9.1), last revised on March 1, 2016, stated:
"The PAC also promotes safety and minimizes risks for residents around medications including the implementation of a comprehensive medication incident reporting program that reviews medication incidents, examines trends and looks at root causes to recommend system changes and reduce risk" and "In the Quarterly Evaluation of the Medication Management System the Professional Advisory Committee: Evaluates the risk of medication incidents and adverse drug reactions in the Home and keeps a written record of each evaluation. The committee reviews Adverse Drug Reaction Reports and Medication Incident/Near Miss Report, recommending changes to prevent or reduce the likelihood of recurrence."

The home's PAC meeting minutes, dated September 13, 2017, were reviewed and

stated, "Medication Incidents were reviewed with corrective action to prevent further occurrences" with no other details related to the specific medication incidents and adverse reactions that were reviewed. The home's PAC meeting minutes dated June 28, 2017, were reviewed and showed no documentation related to the review of any medication incidents or adverse reactions.

The home's Medication Management Committee meeting minutes, dated August 9, 2017, were reviewed and listed the number of medication incidents and adverse events which occurred in the previous three months, but did not include any further documentation to support that each medication incident and adverse event was reviewed in detail to identify factors contributing to the incidents and methods to reduce the risk of similar incidents.

In an interview with the DRC, they shared that each medication incident was reviewed at PAC meetings, but agreed that the PAC meeting minutes did not specify which incidents were reviewed and if any changes were made as a result of the incidents. The DRC stated the home's PAC policy outlined expectations, and the committee should have documented more detail in the minutes to reflect the discussion about medication incidents.

The licensee has failed to ensure that a written record was kept of the quarterly review of all medication incidents and adverse drug reactions, including any changes and improvements identified.

The severity of this issue was determined to be a level two as there was minimal harm or potential for actual harm, and the scope was a pattern during the course of this inspection. The home had no history of non-compliance with this section of the legislation. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is reported to the resident or the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, and, the prescriber of the drug; in addition, to ensure a written record was kept of corrective actions taken as a result of medication incidents, and the quarterly review of all medication incidents and adverse drug reactions, including any changes and improvements identified, to be implemented voluntarily.

Issued on this 5th day of January, 2018

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

Original report signed by the inspector.